CHILDREN'S MEDICAL GROUP, P.A.

PATIENT AUTHORIZATION
FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION
TO THIRD PARTIES
(Sending FROM Children's Medical Group)

INSTRUCTIONS FOR COMPLETION OF THE FORM ON THE FOLLOWING PAGE:

- **Please read the form carefully to ensure that it is completed fully and correctly.**

- **Initially this form provides the ability to indicate anyone other than a parent or legal guardian to whom we can release medical information about your child. (examples: grandparent, aunt/uncle, day care, school, etc.)**

- **This form is also used for one-time medical information release requests to non-parental or guardian individuals, entities or healthcare providers.**

- **When the patient turns 18 years of age, medical information can no longer be released to a parent or legal guardian without the patient's permission. The patient must complete this form to allow medical information to be released to a parent or legal guardian.**

- **If you DO NOT wish to authorize anyone other than a parent or legal guardian to have access to your/your child's medical information, complete the information on the bottom of page 2 and check the box indicating your desire not to release medical information to anyone else.**

- **This authorization form must be updated and signed every 12 months.**

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- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM; HOWEVER, IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED.**
- **WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION.**
- **WE WILL PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

By signing this authorization, I authorize Children's Medical Group, P.A. ("CMG") to use and/or disclose certain protected health information (PHI) about me/my child to the individual(s) or health care provider(s) listed below:

_____

_____

_____

I understand this authorization is at my request and this authorization permits CMG to disclose to my designee(s) the following individually identifiable health information. I understand this may contain treatment notes regarding radiology, pathology ***including HIV test results and genetic testing information***, immunization, procedure(s), ***alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2***, and other common medical record documentation made by the physician, nurse or other ancillary personnel.

Release these records: (Select only one) **Initials**

1. Only records generated by CMG (not including records from other sources) _____
2. All medical records at CMG including records from other clinics/doctors _____
3. Only some portion of records maintained at CMG (date of treatment, etc. - specify below) _____

For #3 above, please indicate dates of treatment for which medical information is needed for release, or specific forms (ex. Vaccination records, camp health forms, sports participation, school or work excuses, school medication administration forms, or college health admission forms)

☐ Vaccination (Shot) Records _____

_____

_____

_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize CMG to release the information specified to the individual(s) or health care provider(s) who I have indicated above, with the **exception** of: (Please initial exception)

_____ Substance abuse, if any _____ Psychological or psychiatric conditions, if any

_____ AIDS/HIV, if any _____ Other (specify)_____

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

When my or my child's information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that CMG has acted in reliance upon this authorization. My written revocation must be submitted to Children's Medical Group, P.A.'s Privacy Officer at 1867 Crane Ridge Drive, Suite 101B, Jackson, Mississippi 39216.

Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

NO AUTHORIZATION DESIRED:

☐ I DO NOT authorize any third party to have access to my/my child's protected health information.

_____ _____

Patient Name Date of Birth

_____ _____

Person Authorized to Sign for Patient (Please print) Relationship to Patient
[Patient name if 18 years or older]

_____

Phone #

X_____ _____

Signature of Authorized Person Date
[Patient must sign if 18 years or older]

For more information on Patient Authorizations, see the Children's Medical Group, P.A. Patient Notice. The Children's Medical Group, P.A. Patient Notice is subject to change. The Children's Medical Group, P.A. Patient Notice can be obtained from the Clinic Manager, any Children's Medical Group P.A. location or online at www.childrensmedicalgroup.net.

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